General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Omnicare Pharmacy Ltd, 160 Causewayside, Edinburgh, Midlothian, EH9 1PR

Pharmacy reference: 9011218

Type of pharmacy: Community

Date of inspection: 28/03/2022

Pharmacy context

This is a community pharmacy on a main road in Edinburgh. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs to people who use the pharmacy and some other pharmacies in the company. And it supplies medicines to care homes. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies and sells a range of over-the-counter medicines. It offers additional services including smoking cessation, seasonal flu vaccination, travel health and vaccination, and ear wax micro-suction. And a chiropractor works from the pharmacy one or two days per week. This pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy suitably manages the risks with its services, including reducing the infection risk during the pandemic. The pharmacy team members mostly follow written processes for the pharmacy's services to help ensure they provide them safely. The pharmacy mostly keeps the records that it needs to by law, and it keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people. They record some mistakes to learn from them, but don't review these regularly to identify common themes. So, they could be missing some learning opportunities.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter. The retail area was large enough to enable social distancing which most people observed. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points daily.

The pharmacy had standard operating procedures (SOPs) which team members mostly followed. They did not comply with the detail of the SOP for managing MCR serial prescriptions, or the SOP for near miss errors. Pharmacy team members had read the SOPs, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members described their roles and accurately explained which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with robust processes followed. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members sometimes used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They discussed incidents at the time but did not routinely review errors to identify trends or training needs. This meant that opportunities to learn and make improvements may be missed. The pharmacy had a complaints procedure and welcomed feedback from people although examples were not discussed.

The pharmacy had an indemnity insurance certificate, expiring 31 December 2022. The pharmacy displayed the responsible pharmacist notice and kept a responsible pharmacist log. Some pharmacists had not signed out of this log to indicate the end of their RP responsibilities. This was a legal requirement. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed a SOP. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. The pharmacy displayed a fair processing notice describing how it handled people's information. Team members had also read and signed a safeguarding SOP and a 'child and vulnerable

adult protection policy'. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people this. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified, competent, and experienced team members to safely provide its services. It supports team members by providing time for training during the working day. Team members make decisions within their competence to provide safe services to people. And they know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had one full-time pharmacist manager, one full-time and one part-time accuracy checking pharmacy technicians (ACPT), one full-time and one part-time dispensers, four part-time medicines counter assistants including one that only worked Saturdays, and a delivery driver. Typically, there were four team members and a pharmacist working at most times. At the time of inspection there was a pharmacist, an ACPT, a dispenser and an MCA. There was also an MCA who usually worked in another pharmacy, who was there to help due to some absence. She had recently started some dispensing activities prior to being registered on an accredited dispensing course. She was 'de-blistering' tablets for the dispensing robot and was observed to be competent and following the SOP for this process. Team members were able to manage the workload. The pharmacy reviewed staffing levels continually and team members worked at different branches to cover gaps. And some part-time team members had scope to work flexibly providing contingency for absence. The pharmacist had worked in this pharmacy for around five months.

The pharmacy provided learning time during the working day for all team members to undertake relevant training and development. The pharmacy gave a team member undertaking NVQ 3 training protected time each week to complete course work. And the care home support officer and care home service manager within the company provided training to relevant team members. Team members had six-monthly development meetings/appraisals with the pharmacy manager to identify their learning needs which were addressed. Team members were observed going about their tasks in a systematic and professional manner and they were competent for the tasks they were undertaking. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open culture environment in the pharmacy where they could share and discuss these. They described feeling able to raise concerns if they had any, with the pharmacy manager, superintendent pharmacist or other pharmacist director. Team members also described continual sharing of information with each other during the working day. And locum and relief pharmacists usually phoned the pharmacy the day before working there. The pharmacy manager passed on relevant information. The company had a whistleblowing policy that team members had read and signed. The company did not set targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and suitable for the pharmacy services provided. The pharmacy has suitable facilities for people to have conversations with team members in private. And it is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, two dispensaries, storage space and staff facilities. Team members used the rear dispensary for assembly of multi-compartment compliance packs as a dispensing robot was in this area and there was adequate space for dispensing, checking and storage of completed packs. The premises were clean, hygienic, and well maintained. Team members cleaned surfaces and touch points daily. There were sinks in the dispensary, staff room and toilets. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available for team members and people using the pharmacy.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and sink which was clean and tidy, and the door closed providing privacy. It also had a treatment room that was mainly used by a chiropractor. The chiropractor had provided most of the furniture for this room as required for this service. This room was also observed to be clean and tidy. Temperature and lighting throughout the premises felt comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them use their medicines. And they provide extra written information to people taking higher risk medicines. The pharmacy obtains medicines from reliable sources and mostly stores them properly. Pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. The pharmacy had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of controlled drugs.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Dispensing team members shared information such as new medicines or dose changes with the pharmacist to enable her to carryout clinical assessments of prescriptions. She used a stamp and initialled prescriptions that were suitable for an ACPT to carry out the final accuracy check. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when people requested them. Team members did not actively monitor compliance, but there was no evidence of people not taking their medicines as prescribed. The pharmacist had not yet carried out pharmaceutical care needs assessments since she had been in this pharmacy, so she had not identified any pharmaceutical care issues.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, at least one week before the first pack was due to be supplied. They kept comprehensive records of each stage of the process including ordering prescriptions. And they kept records of medication changes and relevant clinical information including hospital discharges. They also recorded who had clinically and accuracy checked all dispensing. The dispensing robot assembled medicines in the packs. The pharmacy had adequate shelving for assembled packs to be stored waiting to be checked. An ACPT carried out the final accuracy check and sealed packs. They were then stored in a logical and orderly manner on shelves labelled by day of supply. Each person's packs were stored in a basket labelled with their name, day, and method of supply. Team members included tablet descriptions on backing sheets and supplied patient information leaflets (PILs) with the first pack of each prescription. The pharmacy assembled multi-compartment compliance packs for four other pharmacies in the company, in a 'hub and spoke' model. Team members managed them in a similar way, with additional time built into the process to take account of the delivery time to the other pharmacies. The pharmacist at the spoke branch carried out the clinical checks, recording this on the master sheet which included any changes. The spoke

pharmacy supplied all paperwork to this pharmacy, including the prescription and master sheet, so dispensing took place from the original paper prescription. The pharmacist checked that clinical assessments had taken place before the prescriptions were dispensed. Very occasionally the spoke pharmacist had not done this, so the pharmacist in this pharmacy carried it out. Usually there was enough information provided for her to do this, but if she had any doubt she called the spoke pharmacist to access the patient medication record (PMR). And the pharmacy kept records of calls. The pharmacy included addresses of both pharmacies on the backing sheets. And people knew which pharmacy assembled their multi-compartment compliance packs. The team had robust systems in place to ensure the pharmacy supplied the correct packs to each pharmacy, and on the expected day. Team members used clearly labelled totes showing the destination pharmacy and delivery day. And they segregated people's packs effectively within the totes. The pharmacy also provided pharmaceutical services to care homes. The homes were responsible for ordering their residents' prescriptions and sending them to the pharmacy on an agreed timescale. The pharmacy supplied some medicines in blister packaging, and some in original packs depending on the home's preference. The blister packs were assembled in the robot. The pharmacy followed a timetable to spread the known workload evenly over each week. And team members dispensed acute prescriptions on receipt and delivered these to the home the same day. These prescriptions included new medicines, antibiotics, and analgesics. Team members were trained and competent to undertake the different processes involved in delivering these services.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. Team members were aware of the risks. The pharmacy did not supply valproate to anyone in this group. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. It also followed private PGDs for a variety of services including flu (NHS and private) and travel vaccination (not yellow fever), travel health including prevention of altitude sickness, and sexual health. The pharmacy team members were trained to deliver parts of the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. And the pharmacist delivered the NHS smoking cessation service. Recently the travel health/vaccination service had become busier as travel restrictions had been eased. The pharmacist showed records of recent consultations with people. These were paper based and kept in a folder in the consultation room. The pharmacist discussed how they preferred to record details of the consultation and the risk assessment on paper with the person present, rather than asking the person to pre-fill details online before the consultation. The pharmacist kept records, including batch number and expiry date, of vaccines administered, and utilised a paper diary to keep track of future appointments for further scheduled doses. The pharmacist used a tablet device to access an electronic tool (eTool) for the service, and the NHS pharmacy care record, but not the pharmacy patient medication record (PMR). The pharmacist described a scenario whereby they had used it to check the eTool for suitable antimalarial options as part of a patient consultation. The pharmacist offered an ear-wax removal service which had proved popular recently as many GP practices had stopped syringing ears to remove wax. She demonstrated how the equipment was used. She had completed training and was competent to use it. A chiropractor worked from the pharmacy one or two days per week. The pharmacist had seen certificates of qualification and knew that the chiropractor was registered with the General Chiropractic Council. This service was not a pharmacy service and the chiropractor managed their own appointments within the pharmacy's opening hours.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored most medicines in original packaging on shelves, in drawers and in cupboards. But a few loose tablets were observed on shelves. Team members removed some tablets from original packaging to first place into sealed white plastic containers, then after variable periods, place them into the dispensing robot. They kept records of dates and who carried out and checked these tasks. And team members labelled all containers with drug name, batch number, expiry date, date of re-packaging and initials of both team members involved. At the time of inspection, some medicines had been in the sealed plastic containers for up to nine months (for example, One Alpha capsules) and others for around six months. The pharmacy did not have data to confirm how long medicines could be safely removed from manufacturers' packaging. But there was nothing to suggest that medicines were not fit for purpose. Team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Team members did not know if the pharmacy had a wholesale dealer's licence issued by MHRA and were not monitoring ambient temperatures. But there were areas marked in the pharmacy for 'goods in' and 'goods out' and there were export SOPs. At the time of inspection, the ambient temperature was observed to be within acceptable limits for the storage of medicines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. Pharmacy team members look after this equipment to ensure it works. And they deal appropriately with any faults in equipment.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy used a dispensing robot to fill multi-compartment compliance packs. It was maintained and serviced regularly as recommended by the manufacturer. And team members contacted a service team to report any faults which were addressed in a timely manner, minimising disruption to the dispensing process. The pharmacy kept some equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, sundries required for vaccinations and an ear wax micro-suction device which was maintained in line with the manufacturer's guidance. It was cleaned after each use. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary

The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.